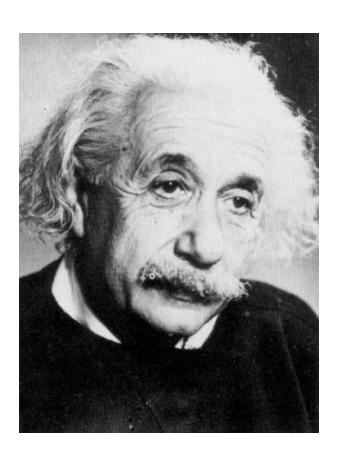
# The significant problems we face cannot be solved at the same level of Thinking that created them.

#### **Einstein**





# MEDICAL HOLDOVER COMMUNITY BASED HEALTHCARE ORGANIZATIONS TRAINING SESSION DECEMBER 2005



# ROLE OF THE CBHCO PHYSICIAN PHYSICAL PROFILES MEDICAL EVALUATION BOARDS OPTIMUM THERAPEUTIC BENEFIT MHO'S WHO HANG AROUND A LONG TIME



COL Michael A. Deaton
Assistant Chief of Staff
Clinical Operations
Great Plains Regional Medical Command





#### FIRST THINGS FIRST...

Arkansas and Utah CBHCO's

- Welcome to Great Plains Regional Medical

Command !!





### WHO NEEDS TO STAY ON ACTIVE DUTY TO RECEIVE TREATMENT?

Four kinds of RC Soldiers need to remain on active duty to receive treatment

- Those who show up with a condition that make them non-deployable, and we don't catch it in the first 25 days
- 2. Those who develop an illness or injury during predeployment training, and they will not be able to return to their units within 60 days
- 3. Those who develop an illness or injury while deployed, and they come back as outpatient MEDEVAC's
- 4. Those who develop an illness or injury while deployed, and need it to be addressed prior to demobilization

## WHAT KINDS OF PATIENTS DO WE HAVE?

Types of Patients	Orthoped ic	Internal Medicine	Mental Health	*Neurologic al
MTF's	1,756	777	260	323
CBHCO's	798	200	80	13

<sup>\* &</sup>quot;Neurological" was not an option in the tracking system until 22 Nov 04. Prior to that time patients with neurological disorders were classified as Mental Health or Other.

#### **CBHCO MEDICAL OFFICER RESPSONSIBILITIES**

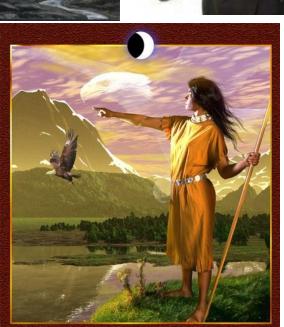
- Maintain appropriate licensure and credentials;
  - Submit documentation to supporting MEDCEN credentials office
- Determine if patient is acceptable for CBHQ
- Develop treatment plan for each patient
  - Document in Outpatient Treatment Reco
- Quality of care for all CBHCO patients
- Medical supervision of Case Managers
- Approval of all referrals for CBHCO Soldiers
- Communicate with physicians and other healthcare providers caring for CBHCO Soldiers

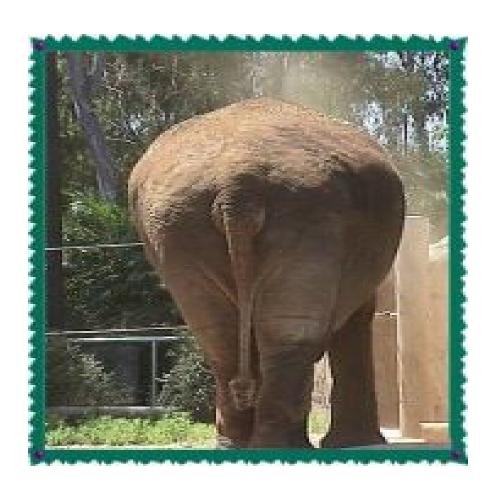
## CBHCO MEDICAL OFFICER RESPONSIBILITIES (Cont'd)

- Review each case at least monthly
  - Document review in outpatient treatment record.
  - Include summary of referrals and diagnostic tests.
    - (Case manager will review / docume least weekly)
- Temporary profiles for CBHCO Soldiers
- Initiate and / or modify permanent profiles
- Prepare / review / approve physicals
- Dictate narrative summaries / initiate medical evaluation boards
- Determination of Optimum Therapeutic Benefit
- Correct medical deficiencies in MEB's as determined by the Physical Evaluation Board

#### **DEATON'S DEFINITION OF CASE MANAGEMENT**







Everyone in the Army has a physical profile

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DD FORM 2808, J AN 2003

**Personal Data** 

**DOB:** 5/25/1958 **SEX:** M **BASD:** 8/11/1983 **CSA/EXPIRE:** / **DTE RET:** 

9/1/2011

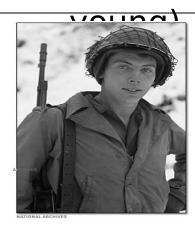
**PULHES/DATE:** 311111 / 5/18/2001 **HEIGHT/WEIGHT:** 71 / 223

COMPONENT: R DTE OF APPT: 5/9/1980 M/D AFCS: 27721

**DUTY PHONE#:** HOME PHONE#:

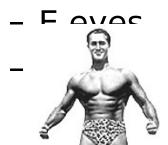
Most Soldiers have a "Picket Fence": PULHES 111111

(At least when they're

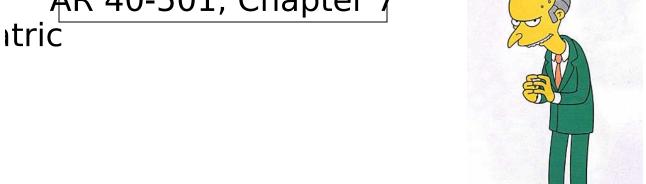


- What does "PULHES" mean?
  - P overall physical condition
  - U upper extremities
  - L lower extremities
    - Backs go here
  - H hearing

- 1 no limitations
- 2 minor limitations, but can still "Soldier on"
- 3 significant limitations
- 4 major limitations



AR 40-501, Chapter 7



- What do we *really* mean when we say a Soldier has, or a Soldier needs a profile?
  - PULHES is something besides 111111
    - Soldier has a condition that limits his / her abilities to perform his / her duties
      - Also means we have a responsibility to protect that Soldier (i.e., the Army's investment) from further injury!
- We need to communicate that information to the Soldier's <u>commander</u>



How do we communicate that information?

	INDIVIDUAL SICK SLIP   ILLNESS   INJURY		DATE
LAST NAME-FIRST NAME-MIDDLE		ORGANIZATION AND STATION	
SERVICE NUMBER/SSN	G R A D E / R A T E		
UNIT COMMANI	DER'S SECTION	M EDICAL O	FFICER'S SECTION
IN LINE OF DUTY		IN LINE OF DUTY	
REMARKS		DISPOSITION OF PATIENT SICK BAY NOT EXAMINED REMARKS	] DUTY QUARTERS  HOS PITAL  OTHER (Specify):
SIGNATURE OF UNIT COMMANDE	R	SIGNATURE OF MEDICAL OFFI	CER
DD FORM 689, MAR 63	PREVIOUS EDITIO	ONS ARE OBSOLETE.	USAPPC V2.00

DD Form 689 "Sick Slip" Temporary conditions only Valid for a maximum of 30 days

Can only get three in a row

<u> </u>												
			SICAL PRO									
For use of this form, see A												
1. MEDICAL CONDITION: (Description in lay terminology)	INJ U I	RY? Or	ILLNESS/	DISEASE?	7-2 AR 40-501)	3.	P	U	L H	E	S	
					7-2 Alt 40-30-2)	Temporary		$\vdash$	_	+	+	
A DROCH C TYPE						Permanent	_	Щ	YES	+	NO	
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								$\rightarrow$	Needs	M	eeds	
C. IF A PERMANENT PROFILE WITH A 3 OR 4 PULHES, DOES THE SOLDIER MEET RETENTION STANDARDS IAW CHAPTER 3 AR 40-501?									MM RB		B/PEB	
5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND T	EMPORA.	RY PROF	IIFS (If any answ	or (a.f) is N	O then the profile should	he at least a 3)					-,	
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e. ABLE TO DO 3-5 SECOND RUSHES UNDER DIRE				o, c.c.,				$\neg$		+		
f. IS SOLDIER HEALTHY WITHOUT ANY MEDICAL				PLOY ME	NT?			$\neg$			$\neg$	
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8. UPPER BODY WEIGHT TRAINING (See FM 21-20)					HT TRAINING (See FN							
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24. PATIENT'S IDENTIFICATION (For typed or written entri	es give: N	ame (Last,	, first); grade;	25. UN	*							
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PHYSICAL PROFILE For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.												
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UNLIMITED BIKING					ACE & DISTANC				$\neg$		+	
UNLIMITED SWIMMING					PACE & DISTAN				$\neg$			
8. UPPER BODY WEIGHT TRAINING (See FM 21-20)			9. LOWER BO	DY WE	GHT TRAINING (S	ee FM 2	1-20)		$\neg$		1	
10. OTHER: e.g. Functional limitations and capabilities	and oth	er comm	ents: (May conti	nue on	11. THESE PAR	RAMET	ERS A RE OPTIO	NAL	USE	AS NI	E DE I	)
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Page 1 of 2

DA FORM 3349, FEB 2004

- Profile Slang
  - Profiles can be
    - Temporary
      - Appropriate if
        - » Condition really is temporary
        - » Or, if condition is permanent, but not yet stable
    - Permanent
  - If the Soldier's condition is temporary, and the PULHES has "3" anywhere in it, it's generally referred to as a "T3" profile.
  - If the Soldier's condition is permanent, and the PULHES has a "3" anywhere in it, it's generally referred to as a "P3" profile.



PHYSICAL PROFILE For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.												
MEDICAL CONDITION: (Description in lay terminology)								P	U	L H	E	S
l	_ ,				7-2 AR 40-5	501)	Temporary					
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10. OTHER: e.g. Functional limitations and capabilities	and oth	er comm	ents: (May conti	nue on	11. THESE PAR	RAMET	ERS A RE OPTIO	NAL	USE	AS NI	E DE I	)
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					Lifting or carrying max weight or distance							
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Page 1 of 2

DA FORM 3349, FEB 2004

PATIENT'S NAME	DATE (YYYYMMDD)
I	
CONTINUATION (From page 1, Item 10)	

DA FORM 3349, FEB 2004

Medical Condition

- Comminuted, open trimalleolar fracture of the left

ankle

Broken ankle

- Functional limitations and capabiliti
  - 0 RMJ
  - Soldier has structural integrity issues of the bony and soft tissues of the ankle. He will require prolonged use of an external fixator. This device must be kept in good repair

dirt and grime. He will be able to ambulate this device in buld use crutches to do so, and then only on even terrain......



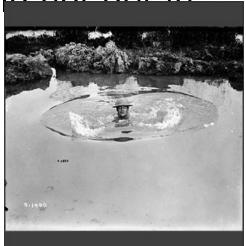
Use Common Sense!!



A Soldier on crutches probably should not take the APFT

A Soldier with a cast on probably should not got in





- Class Rules
- Treat others as you would like to be
- Keep your hands and feet to yourself.
- One person talks at a time
- Use materials responsibly.
- Participate and Think!



- If a Soldier is in medical holdover, the Soldier must have a profile.
  - If he doesn't need a profile, he doesn't need to be in MHO
- Profiles may not be used to exempt Soldiers from requirements of AR 600-9
  - There are ways to do that, but a profile isn't one of them
- No Soldier, AC or RC, may be on a temporary profile for more than year
  - RC Soldiers are only allowed to remain on active duty to receive medical care for one year. After that, a MEB is required.
- All Soldiers with a P3 or P4 profile must undergo either a MMRB or MEB

Just because a Soldier *can* stay in MHO for a year does not mean he *has* to stay in MHO for a year!!

Once he's fixed, it's time to be released from active duty (REFRAD)

If he can't be fixed, when he's hit **optimum therapeutic benefit**, it's time for a Medical Evaluation Board (MEB)

#### WHAT IS A MEDICAL EVALUATION BOARD?

#### MEB

- Three doctors who determine if a Soldier meets retention standards
  - That's all they do: determine if Soldier meets retention standards of AR 40-501
    - Granted, their recommendations influence subsequent events / decisions

#### Doctors



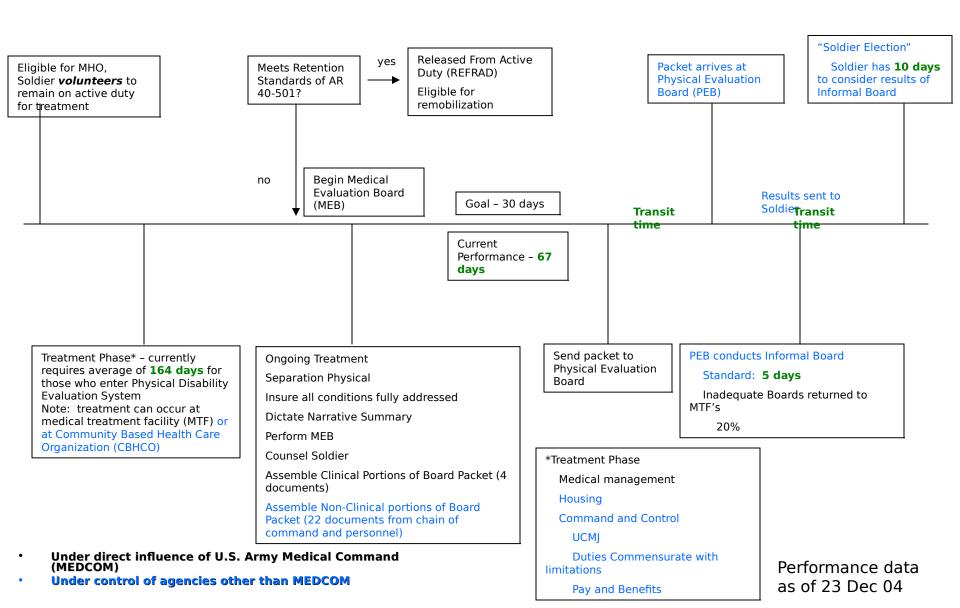
#### WHAT IS A MEDICAL EVALUATION BOARD?

- Do not have to meet formally
  - Each can independently review all the relevant documents
    - If they concur, no need for formal meeting

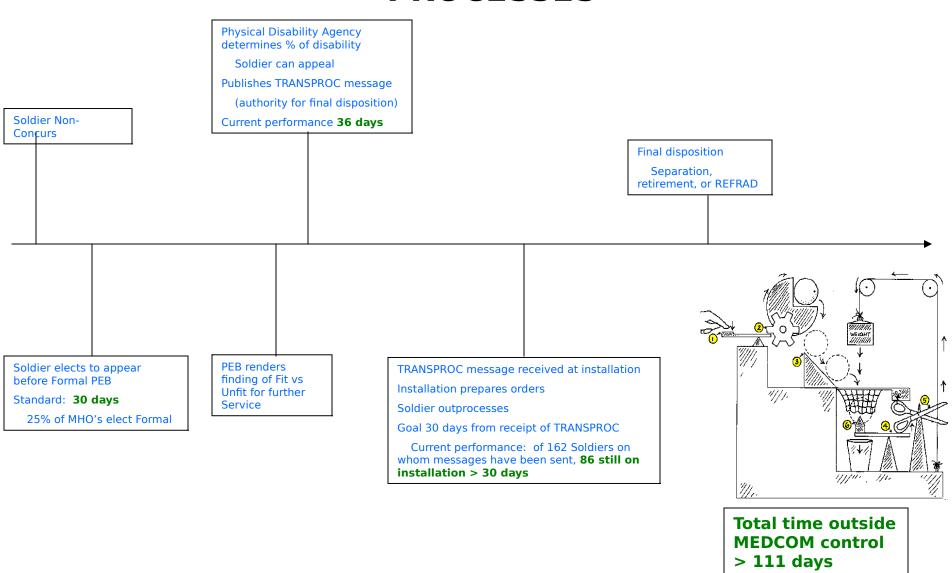




#### **PROCESSES**



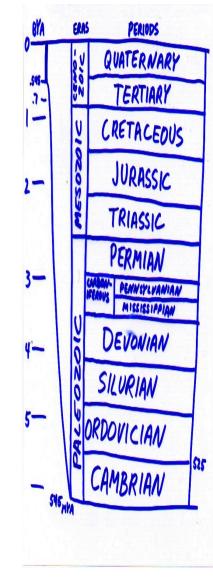
#### **PROCESSES**



- Under direct influence of U.S. Army Medical Command (MEDCOM)
- Under control of agencies other than MEDCOM

#### **MEB STANDARDS**

- Let's look at what has to be done
  - We can look at the timelines later
- Soldier should be at optimum therapeutic benefit
  - As good as we can reasonably get him (or her) without resorting to experimental or extreme measures
- Soldier should have current physical
  - Documented on DD Forms 2807 and 2808
  - Not more than 6 months old at time of submission to Physical Evaluation Board
- All the Soldier's medical issues have been addressed
  - Specialty consults not more than 6 months old



#### WHEN IS IT TIME TO DO A MEB?

- Hopefully <u>never</u>
  - Goal is to *heal* Soldiers and return them to the Army
- However, 35-40% of our MHO Soldiers require a Board

For full details refer to Department of Defense

Instruction 13



#### WHEN IS IT TIME TO DO A MEB?

- In general, it's time to do a MEB when
  - The patient reaches Optimum Therapeutic Benefit
    - Not maximum therapeutic benefit
      - Remember there *is* a difference
  - The patient has been on active duty to receive treatment for a year, and still does not meet retention standards
  - The patient's prognosis is such that he is not likely to meet retention standards even if he receives

treatment for

#### WHEN IS IT TIME TO DO A MEB?

- In general, it's time to do a MEB when
  - The patient reaches Optimum Therapeutic Benefit
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  - The patient's prognosis is such that he is not likely to meet retention standards even if he receives treatment for a year

#### **Example**

- 44 year old white male
- Civilian occupation bank teller
- Military occupation combat engineer in a heavy bridge company
- Chief Complaint sore right shoulder
  - Hurts to work overhead, hurts to reach into the back seat of his car, hurts to lie on right shoulder at night
  - Does "OK" with load bearing equipment
  - Hurts to wear a rucksack with more than 30 pounds in it
- What does he have?
- Does he need a profile?
  - Temporary or Permanent?
- What else would you like to know?

#### Example, Shoulder Impingement, Continued

- Has had this condition for 6 years
  - Has had two courses of physical therapy
    - 6 weeks each
  - Does not want surgery
  - Is tired of putting up with the pain
  - Is embarrassed by the fact that other Soldiers in his company have to "pick up his slack"
- What else would you like to know?

#### **Example, Shoulder Impingement, Continued**

- On exam
  - Point tenderness at the subacromial bursa
  - Pain with abduction
    - Cannot raise his arm far enough to be parallel to the floor
  - Pain with external rotation
  - Pain with resistance maneuvers of the supraspinatus
- Now what?

#### **Army Regulation 40-501**

**Medical Services** 

# Standards of Medical Fitness

**Chapter 3** 

Available on the Web at www.usapa.army.mil

#### **DOES OUR PATIENT NEED A MEB?**

#### 3-12. Upper extremities

- The causes for referral to an MEB are as follows (see also para 3–14):
  - a. Amputation of part or parts of an upper extremity equal to or greater than—
  - b. Joint ranges of motion which do not equal or exceed the measurements listed below.
     Measurements must be made with a goniometer and conform to the methods illustrated and described in TC 8-640.
    - (1) Shoulder—forward elevation to 90 degrees, or abduction to 90 degrees.

#### Who Requires a Medical Evaluation Board?

- AR 40-501, Chapter 3
- 3-3. Disposition Soldiers with conditions listed in this chapter who do not meet the required medical standards will be evaluated by an MEB and will be referred to a PEB with the following caveats:
  - c. A soldier will not be referred to an MEB or a PEB because of impairments that were known to exist at the time of acceptance in the Army and that have remained essentially the same in degree of severity and have not interfered with successful performance of duty.
  - d. Physicians who identify soldiers with medical conditions listed in this chapter should initiate an MEB at the time of identification. Physicians should not defer initiating the MEB...

# 3-4. General policy

 Possession of one or more of the conditions listed in this chapter does not mean automatic retirement or separation from the Service. Physicians are responsible for referring soldiers with conditions listed below to an MEB. It is critical that MEBs are complete and reflect all of the soldier's medical problems and physical limitations. The PEB will make the determination of fitness or unfitness. The PEB, under the authority of the U.S. Army Physical Disability Agency, will consider the results of the MEB, as well as the requirements of the soldier's MOS, in determining fitness.

 It is critical that MEBs are complete and reflect all of the soldier's medical problems and physical limitations.

 The PEB will make the determination of fitness or unfitness.

### **Next Case**

- 28 yo WF with knee pain that began after jumping from HMMWV during roadside bombing.
  - Getting worse, especially with running or stairs
  - Feels like it wants to lock up
  - Exam reveals joint line tenderness to palpation
  - Flexion limited to 45 degrees
  - Prominent "click" on McMurray maneuver
- What does she have ?
- Temporary or Permanent Profile ?
- Does she require a MEB?

# Lower Extremity Case, Cont'd

- Does she require a MEB?
- Not yet!
  - PT x 6 wks, very little improvement
  - MRI confirms medial meniscus tear
  - Arthroscopic surgery cleans up the tear
  - PT x 6 wk, some improvement
    - Still has pain with attempts to run
    - Can get knee to 85 degrees flexion
      - As measured with goniometer
- Does she need a permanent profile?
- Does she require a MEB?

### 3-13. Lower extremities

- The causes for referral to an MEB are as follows (see also para 3–14):
  - a. Amputations.
  - d. Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must
  - be made with a goniometer and conform to the methods illustrated and described in TC 8-640.
    - (2) Knee—flexion to 90 degrees or extension to 15 degrees.

#### **Next Case**

- 55 yo African American male
  - Presented to aid station for minor laceration, but would not stop bleeding
  - "Dang, Sarge, why won't you stop bleeding?"
  - "You think maybe it could have something to do with my Coumadin? They said I might bleed a little easier after I started taking it."
  - MEDEVAC'd
  - History, Physical, and EKG consistent with chronic afib.
  - Patient is otherwise asymptomatic.
  - Should he have deployed in the first place ?
  - Does he need a profile and / or MEB?

#### 3-21. Heart

- The causes for referral to an MEB are as follows (see table 3-1 for functional classifications and for metabolic equivalents (METS) ratings to be included in the MEB):
  - a. Coronary heart disease associated with—
    - (1) Myocardial infarction, angina pectoris, or congestive heart...
  - m. Any cardiovascular disorder requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that would interfere with duty performance.

# NOT A-FIB, BUT STILL THE HEART, Chap 3-21...

- a. Coronary heart disease associated with—
  - (1) Myocardial infarction, angina pectoris, or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The *trial of duty* will be for 120 days.
  - (2) Myocardial infarction with normal coronary artery anatomy. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3– 25) apply. The *trial of duty* will be for 120 days.
  - (4) Fixed obstructive coronary artery disease, asymptomatic but with objective evidence of myocardial ischemia. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The *trial of duty* will be for 120 days.

### WHAT DOES 3-25 SAY?

- 3-25. Trial of duty and profiling for cardiovascular conditions
- a. Trial of duty will be based upon physician recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessment (such as coronary angiography, exercise testing, and newly developed techniques) indicates it is medically advisable.
- b. Prior to commencing the trial of duty period, an MEB will be accomplished in all cases (including evaluation by a cardiologist or internist) and a physical activity prescription on DA Form 3349 will be provided by a physician.

#### MORE ON THE HEART

- 3-25 does not say a Soldier has to remain on active duty for a trial of duty
  - That trial can be done in a drill status
    - If and only if the physician believes the Soldier will receive an adequate trial of duty
- One more thing
  - Do not submit a MEB to the PEB on a cardiac patient without a <u>functional</u> assessment
    - Treadmill
    - NY or Canadian heart failure rating

### **Next Case**

- 19 yo WF recently graduated from AIT,
  - Recurrent episodes of wheezing in the desert
    - Unable to spend more than 2 hrs in protective mask
  - Not sufficiently controlled with intermittent use of albuterol inhaler
  - MEDEVAC'd
  - "I didn't have any trouble since I was 15. Well, that is until I got to Basic. But I managed to tough it out."
  - 10 minutes of running produces 20% decrease in FEV1
  - Can walk 2.5 miles in time to pass alternate APFT
  - Does she have asthma?

# **Wheezing Case**

 Six months after albuterol, salmeterol, fluticasone, and a leukotriene inhibitor, still cannot perform duties in protective mask

Does she need a permanent profile ?

Does she need a MEB ?

 Did she need to remain on active duty to receive an adequate trial of treatment?

- 3-27. Miscellaneous respiratory disorders
- The causes for referral to an MEB are as follows:
- a. Asthma. This includes reactive airway disease, exercise-induced bronchospasm, asthmatic bronchospasm, or asthmatic bronchitis...
  - (1) Definitions/diagnostic criteria are as follows.
    - (a) Asthma is a clinical syndrome characterized by cough, wheeze, or dyspnea and physiologic evidence of reversible airflow obstruction or airway hyperactivity that persists over a prolonged period of time (generally more than 6 to 12 months).
    - (b) Reversible airflow obstruction is defined as more than 15 percent increase in FEVI following the administration of an inhaled bronchodilator or prolonged corticosteroid therapy.

#### **NUANCES OF ASTHMA**

- (d) Soldiers who are diagnosed as having asthma may be placed on a temporary profile under the "P" factor of the physical profile for up to 12 months trial of duty, when medically advisable. If at the end of that period, the soldier is unable to perform all military training and duty as cited below, the soldier will be referred to MEB/PEB.
- (2) Chronic asthma is cause for a permanent P-3 or P-4 profile and MEB/PEB referral if it—
- (c) Results in inability to run outdoors at a pace that meets the standards for the timed 2-mile run despite medications. (d) Prevents the soldier from wearing a protective mask.
- Not all that wheezes is asthma
- Get 3 sets of PFT's before and after meds

# Wheezing Case, Cont'd

- Did she need to remain on active duty to receive an adequate trial of treatment?
  - Probably not
    - Deaton's recommendation
      - T3 Profile for 12 months
      - Trial of Medication
        - » Recommend 12 month trial of duty
      - REFRAD
      - Reevaluate after 12 mo trial of duty

# While We're Discussing Lungs...

- We still have lots of smokers, so...
  - Per Chap 3-27, the following patients require MEB
    - *d.* Bronchitis. Chronic, severe, persistent cough, with considerable expectoration or with dyspnea at rest or on slight exertion or with residuals or complications that require repeated hospitalization.
    - m. Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

### **Back Pain**

- 45 yo WM with recurrent back pain
  - Exacerbated while at JRTC during pre-deployment training
    - Pain every day
      - Hurts to stand longer than 30 min
      - Hurts to sit longer than 30 min, especially in military vehicles
      - Can't bend more than 75 degrees
      - Hurts to extend back to upright
      - Rucksack more than 30 pounds causes exquisite pain
      - No radiation past the knee
      - Has had 12 weeks of PT to no avail
      - Plain films are normal

### **Back Pain, Cont'd**

- Does he need a MRI?
- He would like to try IDET and / or Prolotherapy
  - Should you allow that ?
- Does he require a MEB?
  - Keep in mind there's no demonstrable pathology

#### **BACK PAIN CHAPTER**

- 3-39. Spine, scapulae, ribs, and sacroiliac joints
- The causes for referral to an MEB are as follows (see also para 3-14):
  - e. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.
  - h. Nonradicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease, that fails to respond to adequate conservative treatment and necessitates significant limitation of physical activity.

### **Next Case**

- 26 yo African American male
  - Lieutenant AG Corps, Investment banker as a civilian
  - Spent full year in Theater at a desk
  - Went to gym during de-mob, decided to "Get back in shape."
  - Next day, weak, felt terrible, arm muscles rockhard
  - CPK 103,000
  - What does he have?
  - Does he need a MEB?
  - Did he need to stay on active duty?

- 3-45. Heat illness and injury
- The causes for referral to an MEB are as follows:
- b. Heat stroke.
  - (1) The definitions of heat stroke are as follows.
    - (a) Heat stroke: A syndrome of hyperpyrexia, collapse, and encephalopathy with evidence of organ damage...
    - (b) Exertional rhabdomyolysis
  - (2) Soldiers will be referred to an MEB after an episode of heat stroke or exertional rhabdomyolysis. If the soldier has had full clinical recovery... the MEB may recommend a trial of duty with a P-3 (T) profile. The profile will restrict the soldier from performing.... If the soldier manifests no heat intolerance, including a season of significant environmental heat stress, normal activities can be resumed...

### **Medical Evaluation Boards**

- AR 40-501 describes who needs a MEB
  - How does one go about initiating one ?
    - 1. Make sure <u>all</u> the Soldier's medical problems have been addressed, and have achieved *optimum therapeutic benefit* from treatment
    - 2. Notify the PAD Officer
    - 3. Send the Soldier to see the PAD Officer
    - 4. Arrange for a formal Board Physical
    - 5. Dictate a Narrative Summary

Army Regulation 40-400
Medical Services
Patient
Administration

# **NARRATIVE SUMMARY (NARSUM)**

- For full details refer to AR 40-400, Chapter 7
- NARSUM is the heart of the MEB
  - Nothing more (and nothing less) than a full History and Physical
    - Just like we learned in 3rd year medical school
    - Must be typed
      - Most people dictate
      - You can type it, have it typed, as long as it's typed...



The next several slides are included for your information but will not be covered during class.

That doesn't mean they aren't important. Please take the time to look at them on your own.

Pay special attention to the requirements of orthopedic, cardiology, and neurology cases forwarded to the PEB.

# **The Narrative Summary**

- 7-24. Preparing medical evaluation board narrative summaries
- The recommended format for an MEB narrative summary is provided below.
  - a. Baseline documentation. At the beginning of the MEB, the following will be recorded:
    - (1) The signatory physician's specialty.
    - (2) The clinical department/service.
    - (3) The MTF and its location.
    - (4) Reason for doing the MEB (for example, physician-directed, command-directed).
    - (5) Soldier's eligibility for MEB.

- (6) Military history.
  - "See DA Form 2-1" usually works, but PEB's don't like it
    - » (a) Date of entry into Service.
    - » (b) Estimated termination of Service.
    - » (c) Administrative actions ongoing, pending, or completed (for example, courts-martial, selective early retirement, bars, retirement or separation dates).
- (7) Chief complaint stated **in soldier's own words.**
- (8) History of present illness. Exact details, including pertinent dates regarding injuries, how incurred, and a statement of the final line of duty (LD) determination, if available.

- (9) Past medical history.
  - (a) Past injuries and illnesses.
  - (b) Prior disability ratings (for example, given by the VA).
  - (c) Past hospitalizations and relevant outpatient treatment, including documentation of diagnosis and therapy, pertinent dates, and location should be listed.
  - (d) Illnesses, conditions, and prodromal symptoms, existing prior to service conditions.
- b. Physical examination. A complete physical examination must be recorded in the MEB. (Selected specialty-related considerations and guidelines follow.)
  - "For full physical examination, please refer to DD Forms 2807-1 and 2808. Findings pertinent to the condition for this Board are as follows:..."

- c. Laboratory studies. Studies that support and quantify the diagnosis(es) should be included as should any studies that conflict with the diagnosis(es).
- d. Present condition and current functional status.
   The current clinical condition of the soldier should be noted including required medications and any non-medication treatment regimens (for example, physical therapy) in progress.

- (1) The soldier's **functional status** as to the ability to perform his/her required duty should be indicated.
- (2) The soldier's civilian equivalent performance should be indicated.
- (3) A statement should be given regarding the prognosis for functional status after completion of treatment, if chronic treatment is not necessary.
- (4) A statement should be given regarding the prognosis for functional status in cases requiring chronic treatment.
- (5) The stability of the current clinical condition and functional status should be addressed.

- e. Conclusions.
  - (1) An informed opinion should be stated as to the soldier's ability to meet current retention standards.
  - (2) If a soldier does not meet retention standards, the specific reasons why should be stated.
- f. Diagnosis(es). The diagnostic terminology used by the MEB should correlate, if at all possible, with that of the VASRD. Because the PEBs are required to assess a soldier's status based on the VASRD, a clearer understanding of that status is facilitated when the same terminology is used by the MEBs and the PEBs. All MEB diagnoses will be given an International Classification of Diseases-Ninth Revision-Clinical Modification (ICD-9-CM) code.

- g. Profile (if required by Service regulation).
  - (1) The physical profile of the soldier should agree with the severity of the medical impairment as expressed in the narrative summary.
  - (2) The physical profile of the physical exam should agree with that of the physical profile form, as well as that noted in the MEB cover sheet.
- (These issues are especially troublesome when the doc who does the NARSUM is not the same doc that does the physical.)

- (1) Cardiology.
  - (a) Results of special studies to support and quantify the cardiac impairment should be noted (for example, <u>treadmill</u> and thallium stress tests, angiography, and other special studies).
  - (b) It is imperative that the <u>Functional</u>
    <u>Therapeutic Classification</u> of the cardiac condition be included. Either the New York or Canadian classification system may be used.

- (2) Gastroenterology. Soldiers with fecal incontinence should have recorded findings of rectal examination (for example, digital exam, manometric studies as indicated and radiographic studies). The degree and frequency of the incontinence should be noted, as well as the incapacitation caused by the condition.
- (3) Neurosurgery.
  - (a) In vertebral disc problems, radicular findings on physical examination should be supported by laboratory studies such as computerized axial tomography scan, MRI, or electromyography. In cases where surgery has been performed, both pre- and post-operative deep tendon reflexes should be documented.
  - (b) In head injuries, neuropsychiatric assessment should be accomplished. Results of any clinically indicated neuropsychological testing should be included.

- (4) Ophthalmology. If retention standards are not met for reasons related to vision
  - visual fields must be included in the physical examination and verified by an ophthalmologist.
  - Specialist examination should include uncorrected and corrected central visual acuity.
    - » Snellen's test or its equivalent will be used
    - » and, if indicated, measurements of the Goldman Perimeter chart will be included.

- (5) Orthopedics.
  - (a) Range of motion measurements must be documented for injuries to the extremities. The results of the measurement should be validated and the method of measurement and validation should be stated.
  - (b) In cases involving back pain, the use of Waddell's signs should be included in assessing the severity and character of the pain. (See app A.)

- (7) *Pulmonary.* When an MEB is held for restrictive or obstructive pulmonary disease, documentation will be provided of pulmonary function testing carried out when soldier is on and off therapeutic medication. There must be three pulmonary function tests done off medication, two of which must be in agreement within the 5 percent level, and three done on medication, two of which must agree within the 5 percent level.

#### End of FYI

#### Back to Lecture Material

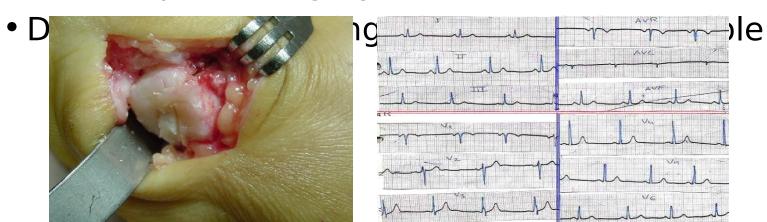
#### **SPECIAL NOTE FOR CBHCO'S...**

- The DoDI does not make allowances for access to civilian health care
  - A year is a year is a year
    - If the Soldier cannot be seen in a timely fashion, maybe it's time to bring him back to an installation to receive care at an Army MTF



#### CBHCO, MTF, WHEREVER...

- Because a year is a year is a year...
  - Attack multiple problems simultaneously, not sequentially
    - Don't wait for the knee to be fixed to start working on the shoulder
      - Back, hip, diabetes, asthma...
    - Sometimes not possible
      - Cardiac function must be fixed before orthopedic surgery



#### WHAT IF...

- If the MEB decides that the patient does not meet retention standards
  - The MEB findings must go to the Physical Evaluation Board (PEB)
    - PEB <u>is</u> a formal board
    - Three of them: DC, TX, WA
      - One doc (two if psych diagnosis)
      - Remainder are line officers
      - President is Combat Arms in terminal assignment
  - Packet contains approximately 28 items
    - Only 4 are medical
      - See AR 40-400 and AR 635-40
      - Assembled by the PEBLO

#### THE STANDARDS

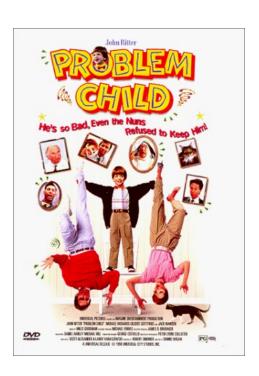
- Department of Defense Instruction
  - MTF has 30 days from dictation of the NARSUM to get the packet to the PEB
- AR 40-400
  - MTF has 30 days from dictation of the NARSUM to get the packet to the PEB
- OTSG/MEDCOM Policy Memorandum
  - MTF has 90 days from date of P3 or P4 profile to get packet to the PEB
- Verbal Order of the MEDCOM Commanding General
  - For Medical Holdover Soldiers
    - MTF has 30 days from the date of the P3/P4 to get packet to the PEB

#### THE STANDARDS

- Department of Defense Instruction
  - MTF has 30 days from dictation of the NARSUM to get the packet to the PEB
- AR 40-400
  - MTF has 30 days from dictation of the NARSUM to get the packet to the PEB
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## ITEMS THAT HAVE CAUSED PROBLEMS WHEN SUBMITTING A MEB TO THE PEB

- Line of Duty Investigation
- Commander's Statement
- Retirement Points
- ERB / ORB
- LES
- BASD
- APFT Data



#### **SECOND OPINIONS**

- All patients to include MHO's are entitled to a second opinion
  - TRICARE Operations Manual
  - At our expense
  - Source of our choosing
    - Foolish if we do not choose someone impartial
  - Third opinions are not an entitlement
    - Patients can get 3rd, 4th, 5th... opinions
    - At their own expense
    - We are not obligated to concu



#### THINGS WE CANNOT / WILL NOT DO

- Cannot / will not
  - Order a physician to perform a procedure or institute treatment that the physician does not think is indicated
    - Cannot order a surgeon to perform surgery
  - Change the PEB's disability rating
    - PEB's work for the Army G1, not the Surgeon General

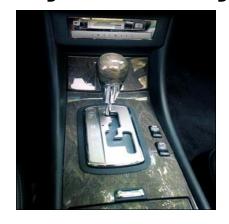
PEB's and PDA rate based on <u>funct</u>

» Not pain

#### **ELECTIVE PROCEDURES**

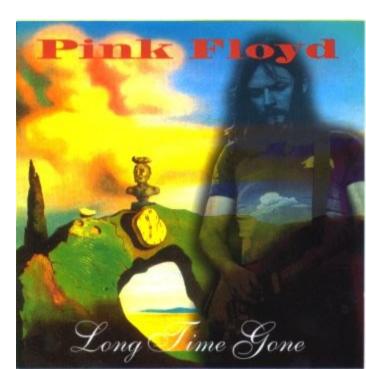
- It <u>is</u> One Army
  - These **are** Active Duty Soldiers
    - They are entitled to the same elective procedures as their Active Component Active Duty compatriots
    - However
      - Primary mission is to overcome condition(s) that put them in MHO
        - » No elective procedures that are likely to prolong time in MHO

## MHO's Who Stay in the Sytem a Long Time



Some MHO's stay with us a very, very, very long time....





 Many of them have very good reasons for staying in the system for a long time



Make sure you know who they are, and can <u>clearly</u> articulate why they're still here

- On the other hand....
  - "I know I came in for my knee. But my knee made me walk kinda funny.
    - I think that's what made my hip start to hurt a couple of months ago.
      - I'm all twisted-like when I walk, and that's causin' my shoulder to ache. You know, I can't lay bricks with my shoulder like this. Did I mention I do brick-layin' sometimes?



And it's just the darndest thing, but I woke one day last week and my hair was itchin'. Not my scalp. My hair! You think all them fumes we breathed in could cause a thing like that? You know I wrote to my congressman about it, but I haven't heard anything back yet..."

- The hard facts
  - At any given moment, there are approximately 5,000 Soldiers in MHO.
    - Every day we shave off their processing time equals \$1.25M



- Intense interest in MHO at DoD/Health Affairs, and at DA
  - Dr. Winkenwerder receives a MHO update every week
  - Vice Chief of Staff of the Army and all the DA Senior Leadership receive a MHO update every week
  - Director of the Army Staff has a MHO briefing every two weeks
  - Surgeon General of the Army receives a MHO briefing every two weeks
    - Interest is highest in those M been in the system more tha

- How do the Senior Leaders at DoD and DA know whether or not a Soldier has a good reason for still being in MHO?
  - Your notes !!
    - Your notes in MODS
      - Medical Operational Data System

Welcome to Medical Holdovers/Active Duty Medical Extension Web Reporting



You have accessed a Department of Defense (DoD) computer system. Please read the WARNING stated below. If you are not an authorized user of this DoD computer system, then you must leave

 Pay close attention to the notes of Soldiers who have been in MHO 270 days or more E 844 2x 2xx

- Other people are paying close attenti-
- Make sure you answer this question: ミ(1+类)(((まき)) ナ・
  - Why is the patient still here?
- Bad note
  - "Needs more PT"
- Good note
  - "IED patient, multiple injuries. 2nd of 5 planned facial reconstructions next week. Anticipate 6 more months."

- 12 gay 8-12 9x

- Memorize this paragraph.
- Teach it to your PCM's and MEB docs.
  - "It is true that not all the patient's medical conditions are currently stable. However, he has been in medical holdover for nearly a year, and all the medical conditions that brought him into medical holdover are stable. Additionally, the patient's demonstrated propensity to develop multiple, new, serial medical conditions makes it highly unlikely that all his conditions will ever be stable. It also makes it unlikely that he will ever ecommend final meet retention

adjudication.

## **Summary**

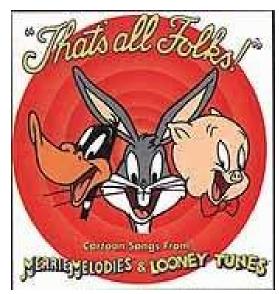
- Physical Profiles
  - Remember the rules
  - Remember the audience
- MEB's
  - AR 40-501, Chapter 3
  - NARSUM, AR 40-400, Chapter 7
- Special Circumstances
  - Second opinions
  - Elective Surgeries
- MHO's who stay with us a long time
  - Some are bona fide
    - Communicate that in your MODS notes



## **Questions?**



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## **Back-up Material**



## Role of the Primary Care Manager



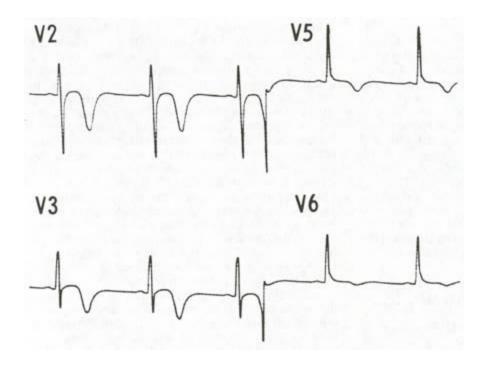
- 50 year old white male, activated Guardsman, E-5, returns from Iraq with chief complaint of low back pain.
  - Referred to orthopedics
    - Evaluated and referred to physical therapy
      - 6 weeks gives some improvement
      - Another 6 weeks doesn't give full improvement
    - Referred to pain management
      - Given epidural steroids
        - » 3 treatments, one month apart
        - » Does not give full relief
        - Referred to neurosurgeon for possible spinal fusion
          - » Neurosurgeon thinks fusion is necessary



- Pre-op evaluation by the anesthetist
  - "Have you ever had any episodes of chest pain, shortness of breath, cold sweats, or dizziness?"



- Pre-op evaluation by the anesthetist
  - "Have you ever had any episodes of chest pain, shortness of breath, cold sweats, or dizziness?"
  - "Sure have. I get like that about twice a week."







- Primary Care Manager's job is to be in charge of the patient's overall care.
  - Patient is informed and part of the team
  - Make sure all needs are addressed up front
  - Care is synchronized
    - Multiple complaints attacked in parallel fashion whenever possible
  - Timely treatment, timely disposition



- Can the PCM do all that, all by himself?
  - No

- That's why you're here !!
  - Coordinate, synchronize,



YOU ARE HERE



## When Patients Don't Agree With Their Care Plans



What to do when patients don't agree with their care plans



- Introductions
  - The DCCS
    - Deputy Commander for Clinical Services
    - Chief of the Medical Staff
    - "Top Doc" in the hospital
      - In most cases, this is the person you work for
  - The Patient Representative
    - Listens to patients' complaints
    - Tries to resolve them
    - Usually works for the DCCS



- Patient Rep
  - First line of defense
  - Trained to hear patient complaints
    - OK, if not trained, they at least get lots of practice
  - Can usually sort things out



- Next step
  - Team Meeting
    - "Multi-D" meeting
      - Patient, Case Manager, PCM
        - » Principal Consultant
        - » (If ortho case, bring in the patient's ortho surgeon)



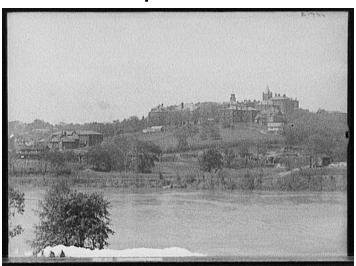
- After that
  - Arrange meeting with DCCS
    - Attendees at DCCS's discretion
      - Some prefer one-on-one
      - Some like to meet in groups
        - » Ask first





- Facts of life
  - Not possible to please everyone
  - Every US citizen has a congressman
    - Introduce yourself to the Congressional Liaison officer
- Rules you should know
  - Every TRICARE Prime beneficiary has a right to a second opinion
    - At our expense
      - We get to say who and where
    - Third, fourth, fifth and sixth opinions are at the patient's expense
      - We are not obligated to abide by them

- More rules you should know
  - Medical Holdover / Medical Retention Processing is voluntary
    - Soldiers must volunteer to be in MHO
      - That means they can REFRAD any time they please
  - Soldiers volunteer to be in the program, but we determine the best place for them to receive care





# Why Health Care Providers Get Sued



COL Michael A. Deaton



Assistant Chief of Staff Clinical Operations



Great Plains Regional Medical Command

## General Continuing Medical Education Information Why Health Care Providers Get Sued

- Jointly Sponsored By U.S. Army Medical Command and BROOKE AMC
- Accreditation Statement: This activity has been planned and implemented in accordance with the
  Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the
  joint sponsorship of the U.S. Army Medical Command and BROOKE AMC. The U.S. Army Medical
  Command is accredited by the Accreditation Council for Continuing Medical Education to provide
  continuing medical education for physicians.
- Credit Designation: The U.S. Army Medical Command designates this educational activity for a
  maximum of 1 category 1 credits toward the AMA Physician's Recognition Award. Each physician should
  claim only those credits that he/she actually spent in the activity.
- **Statement of Need:** When individual providers are tasked to provide more and more access to care, as during times of widespread deployments, patients can perceive they are being rushed, and provided less than the best care possible. This can lead to legal claims. There are things providers can do to minimize their risks of claims.
- Learning Objectives:
  - 1. Identify situations in and reasons why patients say they sue health care providers.
  - 2. Identify the main, underlying reason that causes patients to sue.
  - 3. Utilize various tools that prevent patients from filing claims.
  - 4. Utilize tools that keep patients from wanting to file a claim.
- **Intended Audience:** Physicians, Physician Assistants, Nurse Practitioners, Nurses, Technicians. No prerequisites.
- **Disclosure of Faculty Relationships:** As a sponsor accredited by the ACCME, it is the policy of the U.S. Army Medical Command to require the disclosure of the existence of any significant financial interest or any other relationship a faculty member or a sponsor has with the manufacturer(s) of any commercial product(s) discussed in an educational presentation.
- Michael Deaton: No information to disclose.
- **Disclosure of Committee Member Relationships:** As a CME provider accredited by the ACCME, it is the policy of the U.S. Army Medical Command to require the disclosure of everyone who is in a position to control the content of an activity, to include CME directors, planners, and committee members. The incumbent must disclose any relevant financial relationships with any commercial interest over the preceding 12 month period. Any conflicts of interest need to be resolved prior to the start of the activity.
- Acknowledgment of Commercial Support: There is no commercial support associated with this educational activity.

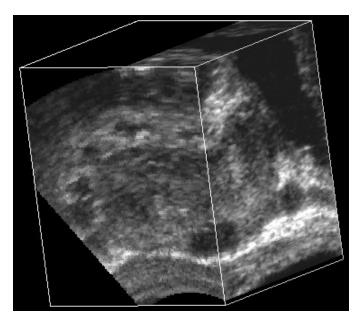
# **Agenda**



- Cases
- Reasons why people sue
- The real reason why people sue
  - Data and studies
- Time-honored recommendations
- Back to fundamentals

### **Example**

- 1996, Occ Health doc at major corporation
  - Performed work physical on a patient
    - Purpose of exam: is patient fit to work?
      - PSA ordered: 5.0.
      - Patient was not notified
      - Next year, PSA > 10
      - Patient notified
      - Patient died
        - » Widow sued



Should the physician have had to pay?

# **Example**

• Physician settled out of court 1.



#### **Next Example**

- Nurse referred by her company for a chest x-ray.
  - X-ray had abnormalities.
    - Company notified.
      - Patient not notified.
        - » Patient developed lung cancer.
        - » Sued company and radiologist.
- Should the radiologist have had to p



# **Example Continued**

Court found that radiologist had a duty to notify 1.

Court's position: you see a patient, you <u>have</u> a provider / patient re'

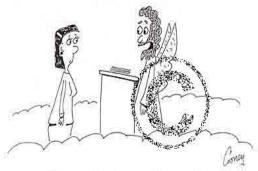
- (Tangent: what are the implications for us and for our patients who want to self-refer?

 Many healthcare organizations allow women to self-refer for mammograms?

- Should we allow that?)

# Why Physicians Get Sued\*

7. Failure to obtain informed consent



"I have no idea how you died, we don't have access to your medical records."

- 6. Negligent procedures
  - Not that the doc isn't trained
    - Doc isn't ready for the game
    - Sleep deprivation is high on the list
- 5. latrogenic drug-related injuries
  - Many due to warfarin



AOT 2 .- THE PANG.

<sup>\*</sup> Seven leading reasons family physicians get sued

# **Why Physicians Get Sued**

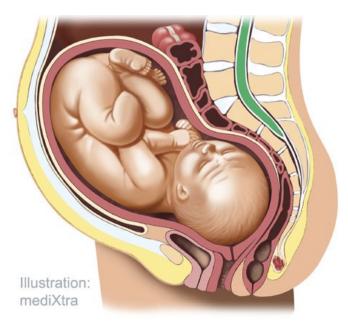


- 4. Failure to consult in a timely manner
  - If you refer on the first visit, you'll come across as ignorant
    - If you wait too long, you'll come across as stupid
    - Try "three strikes and you're out"
- 3. Inadequate trauma care
  - Wrist sprains that are scaphoid fractures
    - Thumb spica's are good for sprains, to
  - Popliteal fossa injuries
    - Check a distal pulse!!



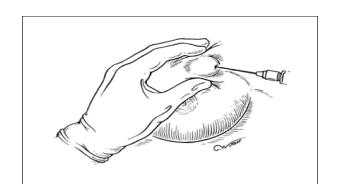
# **Why Physicians Get Sued**

- 2. Maternity care
  - Oxytocin
    - The *doctor* caused the baby to be stressed
  - Somebody else's patient
    - Poor handoff, doctor has inadequate knowledge, complications are unknown, and therefore a <u>surprise</u>





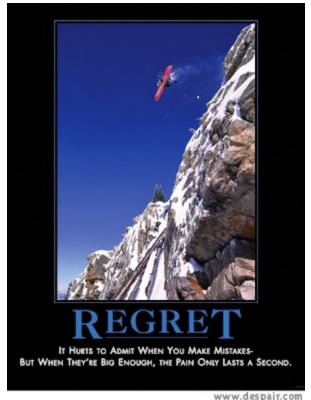
# Why Physicians Get Sued <sup>2</sup>



- 1. Failure to diagnose in a timely fashion
  - Leading diagnosis is breast cancer
    - Beware the negative mammogram
      - » Mammography designed as a screening exam
    - Lumps have to go away
      - » They can go away by themselves
      - » We can make them go away

# Why Do Patients Sue Their Providers?

- Think back to the first two examples
  - Why didn't these patients / families say "Oh, well." If that's not your responsibility...."
    - Patients want someone to be accountable 2.



# Why Do Patients Really Sue Their Providers?

• Because they're **angry**!!



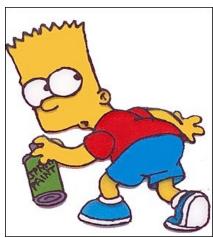
#### Need to be Convinced? 4

- Vanderbilt, 645 physicians, 1992-1998, 18,851 complaints in 7,977 separate reports,135 lawsuits
  - Surgeons twice as likely to get sued as nonsurgeons
  - Males more likely to get sued than females
  - 10% of physicians generated > 50% of the complaints
  - Surgeons who got sued had 2.7 times the number of complaints as their peers

# More Facts and Figures <sup>4</sup>

- Of physicians who were sued
  - High productivity had a direct correlation with likelihood of being s

- What did their patient complaint files reveal?
  - Did not listen
  - Would not return phone calls
  - Rude
  - Disrespectful



# **Need More Convincing?** 5

Different study: 963 OB patients and their OB/Gyn's in Florida

- OB/Gyn's who had been sued had 2 x complaints as peers
- Comments about OB/Gyn's who had been sued
  - Rushed during visits
  - Ignored
  - Questions unanswered



#### Further Evidence 6

- Mothers of infants who experienced perinatal injury or death
  - Florida, 1986-1989
  - 127 moms
    - Why did they sue?
      - Recognized cover-up: 24%
      - Wanted more information: 20%
      - Revenge: 19%

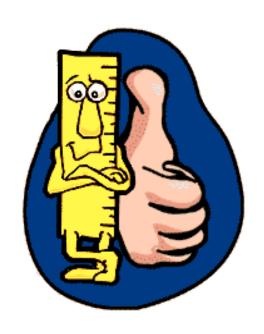
- Medi 33%



d them to sue:

# **How to Stay Out of Trouble 2**

• Some "Rules of Thumb" and other assorted tips...



Angry patients sue



• Be compassionate

- Without warning, you get orders for Fort Elsewhere.
  - How do you feel?



- Patients don't like to be mushrooms
  - Talk to them
  - Communicate
    - In a compassionate manner



- Taking time off from work for a complication you didn't expect: \$800
  - Consulting a reputable attorney: \$150
    - Finding out the doctor wasn't up to date:
       priceless.
      - For everything else, there's your attorney



- Patients sue when they can say "Gotcha!"
  - No one can know everything
    - Embrace clinical practice guidelines
    - Be competent
      - Why do you think aviators have pre-flight checklists?



- The medical record is there to document what happened, and to provide continuity of care: <u>true!</u>
  - It's also there to cover your backside!!



- If it isn't documented, it didn't happen
  - Chart what you did
  - Chart what you didn't do, and why not



- While we're discussing charting and "Gotcha!"
  - Don't ever, ever change the chart !!
    - OK to make corrections.
    - Never OK to make cover-ups.

Nymph of the downward smile, and sidelong glance, In what diviner moments of the day Art thou most lovely? When gone far astray Into the labyrinths of sweet utterance?

Or when serenely wand'ring in a trance

Of sober thought? Or when starting away With careless

robe, to meet the morning ray...

- John Keats, 1884

- Don't embellish in the chart
  - Stick to the facts
    - "Drunk and obnoxious" will get you sued
    - "Patient is combative. Ethanol-like odor noted." is much less litigious.

# If We Beg the Question Just a Bit Further....

What's the real motivation behind patients'

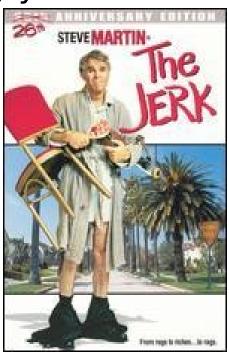
malpractice claims?



- They're **angry** 

# **Why Health Care Providers Get Sued**

Why are they angry?



- They perceive that the provider was a **jerk** 

#### What Can We Do 3,7?

- Go back to fundamentals
  - Sit down

Doc standing up, with his hand on the doorknob

- Impression is he's in a hurry to get out of the

room



#### What Can We Do?

- Go back to fundamentals
  - Listen
    - Some studies show we interrupt the first time
      - in as little as **18 seconds** 
        - 90% of what we want to know will come out in approximately 3 minutes if we will just



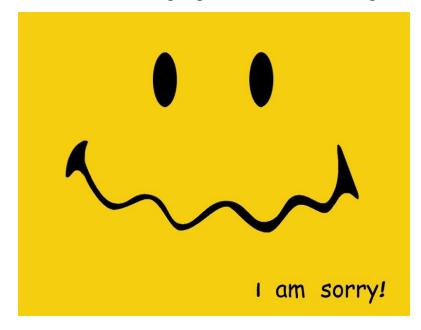
#### What Can We Do?

- Go back to fundamentals
  - Interact with the patient as a person
    - Person does not want to be known as "The puker in Exam 3"
    - Person came to interact with you
      - Not to watch you interact with a computer



#### What Can We Do?

- Go back to fundamentals
  - Remember what you learned in kindergarten
    - If you make a mistake
      - Say you're sorry
        - » Don't admit guilt
        - » Do say you're sorry



### **Summary**

- Cases
- Reasons why people sue
- The real reason why people sug
  - Data and studies
    - They're angry
- Time-honored recommendation
- Back to fundamentals
  - Sit down
  - Don't rush
  - Treat people like they're people
  - When appropriate, say you're sorry



# **Questions?**

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